Family Voices Network of Erie County
www.familyvoicesnetwork.org

Referral Process Form

Family Voices Network of Erie County
c/o Elizabeth Benitez
478 Main St., Floor 2 * Buffalo, NY 14202
Telephone: (716) 858-2192 – Fax: (716) 858-7492

REFERRAL COMPLETED: / /

IMPORTANT NOTE: This application cannot be processed unless all portions are legible and complete. PLEASE PRINT CLEARLY OR TYPE.

You *must* select one of the options below for this referral:

	Care Coordination/Wraparound		**Family Court Designated Wrap Referral (6 mo. Placement)**

or

	Community Residence (CR)*		**Residential Treatment Facility(RTF)***

(*) NYS Office of Mental Health requires that SPOA process these applications prior to submission to determine the appropriate level of care.

Referred Youth's Information

Name: (Print first name, middle initial, last name)	Gender: □ Male □ Female	Date of Birth:
Address: (Print home address, city, state, zip code, county)		Phone #:
Primary Language Spoken:	Secondary Language (if any):	
□ My family reads and speaks English at home	□ My family speaks a different language at home:	
My family needs an interpreter: □ Yes □ No	If different language, please list:	
Medicaid Eligible: □ Yes □ No	If, yes, please provide Medicaid # (CIN):	

Race/Ethnicity: (If Hispanic/Latino, choose from Section B; all others, choose from Section A)

Section A:	**Section B:**
□ American Indian/Alaska Native	□ Mexican
□ Asian	□ Puerto Rican
□ Black or African American	□ Cuban
□ Native Hawaiian or Other Pacific Islands	□ Dominican
□ White	□ Central American
□ Biracial (Specify):	□ South American
□ Other (Specify):	□ Other (Specify)

Parent or Caregiver Information

Name: (Print first name, middle initial, last name)		Relationship to Youth:
Address: (Print home address, city, state, zip code, county)		
Home Phone #:	Work Phone #:	Other Phone #:
Email Address:	**Best Time To Call:**	
Primary Language Spoken:	Secondary Language (if any):	

Additional Parent or Caregiver Information

Name: (Print first name, middle initial, last name)		Relationship to Youth:
Address: (Print home address, city, state, zip code, county)		
Home Phone #:	Work Phone #:	Other Phone #:
Email Address:	**Best Time To Call:**	
Primary Language Spoken:	Secondary Language (if any):	

Other Important Contacts

If we cannot contact one of the parents or caregivers, please list the name of an additional involved contact person (as examples – grandparent, adult sibling, aunt/uncle):

Name:	Relationship to Youth:	Phone:

Erie County Department of Social Services Custody? □ Yes □ No	
ECDSS Caseworker's Name:	Phone #:
Email Address:	

Sibling Information (attach additional sheet as needed)

Name (First & Last)	Gender M/F	Date of Birth	Relationship to Youth	School/Grade	Current Residence

Current System Involvement of Youth *(Select all that apply)*

	Contact Person	Phone #	Email Address
□ Juvenile Justice (PINS/JD)			
□ Special Education			
□ Family Court			
□ Probation			
□ School			
□ Mental Health Agency/Clinic/Provider			
□ Hospital			
□ Physical Health Care Agency/Clinic/Provider			
□ Erie County Department of Social Services			
□ Substance Abuse Agency/Clinic/Provider			
□ Other (Please specify)			

School Information

School District:		
School Name:		
Placement (Size of class, identification, Please check one below):		Grade:
□ Regular Education □ 504 □ Resource Room	□ Special Education □ 12:1:1 □ 15:1:1 □ 6:1:1 □ 8:1:1	□ Other: (Please specify)
Is the attendance of the youth an issue/concern? □ No □ Yes, if so list why?		

What were the problems leading to the referral for services? (*Check and circle all that apply*)
□ Suicide-related problems (including suicide ideation, suicide attempt, self-injury)
□ Depression-related problems (including major depression, dysthymia, sleep disorders, somatic complaints)
□ Anxiety-related problems (including fears and phobias, generalized anxiety, social avoidance, obsessive-compulsive behavior, post-traumatic stress disorder)
□ Hyperactive and attention-related problems (including hyperactive, impulsive, attention difficulties)
□ Conduct/delinquency-related problems (including physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away, sexual assault, fire setting, cruelty to animals, truancy, police contact)
□ Substance use, abuse, and dependence-related problems
□ Adjustment-related problems (including changes in behaviors or emotions in reaction to a significant life stress)
□ Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors)
□ Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, stereotypes, perseverative behavior)
□ Specific developmental disabilities (including enuresis, encopresis, expressive or receptive speech and language delay)
□ Learning Disabilities
□ School performance problems not related to learning disabilities
□ Eating Disorders (anorexia, bulimia, obesity)
□ Trauma (community violence, school violence, complex trauma, domestic violence, medical trauma, natural disasters, neglect, physical abuse, refugee and war zone trauma, sexual abuse, terrorism, traumatic grief)
□ Other Problems (Please specify):

Current Living Situation of Youth	
□ Two Parent Family	□ Family Based Treatment
□ One Parent Family	□ Therapeutic Foster Care
□ Two Parent Adoptive Family	□ Runaway Shelter/Homeless
□ One Parent Adoptive Family	□ Residential Treatment Center (OCFS/DSS)
□ Grandparent(s)	□ Residential Treatment Facility (OMH)
□ Other Relative's Home	□ Detention
□ OCFS/DSS Family Foster Care	□ Acute Care Inpatient
□ Community Residence (OMH)	□ State Psychiatric Inpatient
□ OCFS/DSS Group Home	
Anticipated discharge date from above (If applicable):	

Out of Home Placement Due to Family Court:		
Is placement related to Child Welfare?	□ Yes	□ No
Is placement related to Juvenile Justice?	□ Yes	□ No

During the Past 6 Months, was the Youth the Recipient of any of the Following? *(Select all the apply)*	
□ Medicaid	□ TANF
□ Child Health Plus	□ Private Insurance
□ Social Security Survivor Benefits & Amount: _____	
□ (SSI Benefits) Social Security Disability Income & Amount: _____	
□ Other (please specify)	

DSM Diagnosis Source (provided within last 12 months preferably)

Which professional source made the diagnosis as indicated in the following information below?

□ Child Psychiatrist	□ Licensed Social Worker	□ Child Psychologist
□ General Psychiatrist	□ Nurse Practitioner	□ General Psychologist
□ LMHC	□ Other: _____	

Name of Clinician: Date of Diagnosis:

DSM Diagnosis Information

AXIS I DIAGNOSIS: CLINICAL DISORDERS (*Please list Axis 1 Primary Diagnosis first.*)

AXIS II DIAGNOSIS: PERSONALITY DISORDERS, MENTAL RETARDATION (If any)

AXIS III DIAGNOSIS: GENERAL MEDICAL CONDITIONS (If any)

AXIS IV DIAGNOSIS: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS
(*Select all that apply*)

□ Problems with primary support group	□ Economic problems
□ Problems related to the social environment	□ Problems with access to health care services
□ Educational problems	□ Occupational problems
□ Other psychosocial and environmental problems	□ Housing problems
□ Problems related to interaction with the legal system/crime	

AXIS V DIAGNOSIS: GLOBAL ASSESSMENT OF FUNCTIONING (GAF)

ENTER GAF SCORE: ☐	**Important**: The child or youth GAF score must be under 50 to qualify as a serious emotional disturbance (SED). Assessment criteria for this score can be found by visiting www.familyvoicesnetwork.org

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CRITICAL INFORMATION FOR ELIGIBILITY

IMPORTANT: Eligibility factors are largely based on risk of out-of-home placement or hospitalization. When completing this summary, **be explicit and detailed including the level of severity and frequency of the behaviors** which illustrate why the youth is at severe risk for out-of-home placement.

At-Home: (ex. safety concerns for youth and/or family, rebellious, curfew violations, physical aggression, trauma)

In School: (ex. attendance, suspension, altercations, weapons, CPS involvement)

In Community: (ex. known to police, past involvement with Crisis Services, Juvenile Justice, substance abuse)

Youth & Family Strengths

Describe youth and family **strengths** that will assist in keeping the youth at home and within the community; or, what **strengths** will assist in the successful return of the youth from placement.

C.A.F.A.S. Information (where available)

C.A.F.A.S. Attached □ Yes □ No

C.A.F.A.S. Completed Date: _____ C.A.F.A.S. Total Score: _____

Domains (10):

School/Work Role Performance		Moods/Emotions		**Parent/Caregiver:**	
Home Role Performance		Self-Harmful Behavior		Material	
Community Role Performance		Substance Use		Supports	
Behavior Toward Others		Thinking			

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Care Coordination/Wraparound/ SPOA Process Authorization Form

My Voice, My Choice:

Family Voices Network (FVN) of Erie County recognizes that families have a voice and choice while enrolled in Care Coordination services. I, as the parent/caregiver, understand my family's strengths and needs are identified during our enrollment in Care Coordination services. I also plan to work with a team of people to help create a Plan of Care that will work best for my family.

I acknowledge my family will receive services from one of the Care Coordination agencies listed below and that I also have a choice to identify an agency that I do not want to work with.

Please check one choice below:

☐ I do not have an agency preference based on the list below ☐ I prefer not to be assigned to:_____
(Please be aware that by choosing this option it <u>may</u> delay your assignment for services.)

1. Child & Adolescent Treatment Services (CATS)
2. Child & Family Services, Inc. (CFS)
3. Gateway-Longview
4. Mid-Erie Counseling & Treatment Services
5. New Directions Youth & Family Services

Parent/Guardian Name (please print): _____

Signature: _____ Date: _____ Phone: _____

For Referral Source Submitting this Referral Application:

Below is a list of required forms to expedite this application. By signing below, you indicate that you have included all the necessary forms/documentation for this family's application for Care Coordination services. Please check all that are included in the total referral submission.

	Permission to Use & Disclose Confidential Information (form attached to FVN Referral Application)
	Parent/Caregiver Authorization for Referral of Services (listed above)
	Copy of the **Psychiatric Evaluation** (within last 12-months) if available
	Copy of the **"Discharge Plan"** if youth is in placement or hospital

I confirm that the information submitted in the referral application is reflective of the current status of the family. I will ensure the FVN Referral Application and supporting documentation is submitted to FVN within 48-hours of the parent/guardian signature listed above.

By signing application I assert referral is complete and Care Coordination services were explained to the family.

Your Name (Print): _____ Agency/Department:_____

Address: (Print address, city, state, and zip code) _____

Your Signature: _____ Date: _____

Email Address: _____ Telephone Number: _____ Fax Number: _____

Supervisor/Program Director Name: _____

Phone: _____ Email Address: _____

Pertaining to Which System? (Circle One) Juvenile Justice, Mental Health, Social Services, School, Family, System of Care, Other

CONSENT FORM

Permission to Use and Disclose Confidential Information

Important: Both pages of this agreement must be submitted with the Referral Form. If not, the referral form will be returned as we can not process the application without the confidentiality disclosure and appropriate signatures.

This form is designed to be used by organizations that collaborate with one another in planning, coordinating, and delivering services to persons diagnosed with mental disabilities. It permits use, disclosure, and re-disclosure of confidential information for the purposes of care coordination, delivery of services, payment for services and health care operations. This form complies with the requirements of § 33.13 of the New York State Mental Hygiene Law, federal alcohol and drug record privacy regulations (42 CFR Part 2), and federal law governing privacy of education records (FERPA)(20 USC 1232g). It is not for use for HIV-AIDS related information. Although it includes many of the elements required by 45 CFR 164.508(c), this form is not an "Authorization" under the federal HIPAA rules. An "Authorization" is not required because use and disclosure of protected health information is for purposes of treatment, payment or health care operations. (See 45 CFR 164.506.)

1. I hereby give permission to use and disclose health, mental health, alcohol and drug, and education records as described below.

2. The person whose information may be used or disclosed is:

Youth Name:	**Date of Birth:**

3. The information that may be used or disclosed includes (check all that apply):

- ☐ Mental health records (print or electronic)
- ☐ Alcohol/Drug Records
- ☐ School or Education Records
- ☐ Health records
- ☐ All of the records listed above

4. This information may be disclosed by (see attachment A):

- ☐ Any person or organization that possesses the information to be disclosed
- ☐ The persons or organizations listed in Attachment A
- ☐ The following persons or organizations that provide services to me:

5. This information may be disclosed to (see attachment A):

- ☐ Any person or organization that needs the information to provide service to the person who is the subject of the record, pay for those services, or engage in quality assurance or other health care operations related to that person.
- ☐ The persons or organizations listed in Attachment A
- ☐ The following persons or organizations:

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6. The purposes for which this information may be used and disclosed include:

   - Evaluation of eligibility to participate in a program supported by the Erie County Department of Mental Health;
   - Delivery of services, including care coordination and case management;
   - Payment for services; and
   - Health Care Operations such as quality assurance.

7. I understand that New York and federal law prohibit persons that receive mental health, alcohol or drug abuse, and education records from re-disclosing those records without permission. I also understand that not every organization that may receive a record is required to follow the federal HIPAA rules governing use and disclosure of protected health information. I HEREBY GIVE PERMISSION TO THE PERSONS AND ORGANIZATIONS THAT RECEIVE RECORDS PURSUANT TO THIS AUTHORIZATION TO RE-DISCLOSE THE RECORD AND THE INFORMATION IN THE RECORD TO PERSONS OR ORGANIZATIONS DESCRIBED IN PARAGRAPH 5 FOR THE PURPOSES PERMITTED IN PARAGRAPH 6, BUT FOR NO OTHER PURPOSE.

8 **This permission expires (check applicable box):**

☐ On _____ (date); ☐ Upon the following event: _____

9. This permission is limited as follows:

☐ Permission only applies to records for the following time period:

From (date):	**To (date):**

☐ Other limitation: _____.

10. I understand that this permission may be revoked. I have received a Notice of Privacy Practices, and understand that if this permission is revoked, it may not be possible to continue to participate in certain programs. I will be informed of that possibility if I wish to revoke this permission. I also understand that records disclosed before this permission is revoked may not be retrieved. Any person or organization that relied on this permission may continue to use or disclose records and protected health information as needed to complete work that began because this permission was given.

I am the person whose records will be used or disclosed. I give permission to use and disclose my records (print and/or electronic) as described in this document.

Signature:	**Date:**

I am the personal representative of the person whose records will be used or disclosed. My relationship to that person is _____. I give permission to use and disclose my records (print and/or electronic) as described in this document.

Print Name:	
Signature:	**Date:**

CONSENT FORM

Permission to Use and Disclose Confidential Information

Attachment A

(For your records, do not submit to Family Voices Network)

This permission to disclose records applies to the following organizations and people who work at those organizations. These organizations work together to deliver services to residents of Erie County. If your organization submitted a "Referral Form" and "Permission to Use and Disclose Confidential Information" you will receive a notice regarding the status of the submitted application.

Alcohol & Drug Dependency Services	Hillside Children's Center
Baker Victory Services	Hispanics United of Buffalo
Brylin Hospital(s)	H. Jeffrey Marcus, Attorney At Law
Buffalo Urban League	Horizon Health Services
Crisis And Re-Stabilization Emergency Services	Jewish Family Services
Catholic Charities	Kaleida Health
Child & Adolescent Treatment Services	Kaleida Health: Children's Psychiatry Outpatient Clinic
Child & Family Services	Katie Miller, LMHC
Community Action Organization of Erie County	Lisa Gratto, LCSW
Community Connections of NY, Inc.	Matthew Jost, LCSW-R
Compass House Inc.	Mental Health Association
Compeer of Greater Buffalo	Mid-Erie Counseling & Treatment Services
C.O.U.R.T.S. Program	Monsignor Carr Institute
Eating Disorders of WNY Inc.	Native American Community Services
Erie County Department of Mental Health	New Directions Youth & Family Services
Erie County Department of Probation	People Inc.
Erie County Department of Social Services	Robert Hehir, LMSW
Erie County Medical Center	Southwest Keys
Erie County Family Court	Spectrum Human Services
Families' Child Advocacy Network	The Family 25, Inc.
Family Help Center	Transitional Services, Inc.
Gateway – Longview, Inc.	Tutor Doctor
Goldstein, Ackerhalt, & Pletcher – Attorneys At Law	U.B. Department of Family Medicine
Heritage Centers	WNY Children's Psychiatric Center
H.E.A.R.T. Foundation	Zion Community Services Inc.